

HEADACHE/MIGRAINE HISTORY & ASSESSMENT FORM

****Forms must be completed in their ENTIRETY***

*****Bring a list of your MEDICATIONS***

PERSONAL HISTORY

Date: _____

Last Name: _____ First Name: _____

Date of Birth: D _____ M _____ YR _____ Age: _____ Height _____ Weight _____ Sex: M / F / Other

OHIP (health card) #: _____ Version Code: _____

Address: _____ City/Town: _____ Postal Code: _____

Telephone: (_____) _____ Cell: (_____) _____ Work: (_____) _____

Preference of which number to call you: (please circle) HOME / CELL / WORK May we leave a voicemail? YES / NO

*Email: _____ Occupation: _____

Do you have a private / extended healthcare plan? Y / N Name of provider(s): _____

MEDICAL HISTORY

Family Physician: _____ Address: _____

Are you currently **pregnant or breastfeeding**? Y / N Are you planning a **pregnancy** within the next year? Y / N

Major illnesses or Surgeries [PAST or PRESENT] (cancer, diabetes, surgery, etc.): _____

Do you have any **upcoming/planned procedures/surgeries**? Y / N _____

Do you have any **neurological** conditions? [i.e. myasthenia gravis, multiple sclerosis, ALS, Lambert-Eaton syndrome, Bells Palsy, etc.] Y / N

Current health conditions/diagnoses (please include everything, even if you may feel it is not relevant/significant): _____

Please list any **current medications** including vitamins, herbal supplements (include dosage if able): _____

Are you taking **blood thinners** [anti-coagulant or anti-platelet medications]? Y / N If yes, please explain: _____

Please list any **Allergies** [foods, medication, environmental, other]: _____

Do you smoke? Y / N How much/often? _____

Have you ever used botox before? Y / N How so? (please circle): Medically Cosmetically

You may NOT have Botox if you are pregnant, breastfeeding, or during the first three months following delivery.

HEADACHE HISTORY

(Please note: Any type of headache counts during the following questions, not just the ones you may consider "migraines". Days when headaches were successfully treated with migraine-specific acute medications (e.g. triptans) are also considered headache days.)

Onset:

At what age did the headaches start? Age: _____ How long have you suffered with headaches? _____

Frequency of headaches:

In the last month (past 30 days), on how many days did you have a headache? _____

In the last 3 months (past 90 days), on how many days did you have a headache? _____

***If you cannot recall how many headache days you have had, try counting the number of **headache-FREE** days to help you determine.*

Duration of headaches:

How long do your headaches usually last? (please circle) Minutes Hours Days

If you chose hours or days, **how many hours at a time** do your headaches usually last? _____ hours

Symptoms/features of headaches (past 30 days): (please circle)

Sensitive to light (felt more comfortable in a dark place)? Never Rarely Less than half the time More than half the time

Sensitive to sound (felt more comfortable in a quiet place)? Never Rarely Less than half the time More than half the time

How often was the pain moderate to severe? Never Rarely Less than half the time More than half the time

How often did you feel nauseated/sick to your stomach? Never Rarely Less than half the time More than half the time

Please circle any other symptoms you have experienced: Vomiting One-side of head only Both sides of head
Front of head/back of head Pulsating/throbbing
Sharp/stabbing Pressure/Squeezing Tension
Inability to work/function Other: _____

Presence of Aura? **Y / N** (Aura: sensory disturbances can include: flashes of light, blind spots, vision changes or tingling in your hand/face).

Please describe: _____

During headaches, do you experience any pain in other areas/muscles? (jaw, eyes, ears, neck, shoulder, etc) **Y / N** If so, please explain:

Aggravating factors/triggers: (circle all that apply)

Physical activity Mental exertion/concentration Computer use/eye strain Stress Sleep deprivation Driving

Trauma Dehydration Diet (chocolate / alcohol / caffeine / cheese / spices or flavourings) Other: _____

Medication use (past 30 days):

How many days did you use over-the-counter medications to treat your headache attacks? _____

How many days did you use prescription medications to treat your headache attacks? _____

Previous diagnostic investigations: (please circle)

Have you had any of the following investigations/tests completed in the past year? CT Scan MRI Sleep test/study

Ophthalmological testing

Emergency room visits related to headaches? # of visits _____

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in comparison to feeling just tired?

- 0 = would never doze
- 1 = slight chance of dozing
- 2 = moderate chance of dozing
- 3 = high chance of dozing

Situation	Chance of dozing (0 = low, 3 = high)
Sitting and reading	
Watching TV	
Sitting still in a public place (e.g. a theatre, a cinema or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when the circumstances allow	
Sitting and talking to someone	
Sitting quietly after lunch without having drunk alcohol	
In a car or bus while stopped for a few minutes in traffic	
TOTAL	

PHQ9		0	1	2	3
Over the last <u>two weeks</u> how often have you been bothered by the following problems?		Not at all	Several Days	More than half the days	Nearly every day
A	Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B	Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C	Trouble falling or staying asleep, sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D	Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E	Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G	Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H	Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I	Thoughts that you would be better off dead or of hurting yourself in some way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Severity Score	Mild depression = 5 – 10 Moderate depression = 10 – 18 Severe depression = 19 – 27	Total Score:			
	If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

GAD7 Over the last two weeks how often have you been bothered by the following problems?	0 Not at all	1 Several Days	2 Over than half the days	3 Nearly every day
Feeling nervous, anxious, or on edge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not being able to stop or control worrying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worrying too much about different things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble relaxing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being so restless that it's hard to sit still	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Becoming easily annoyed or irritable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling afraid as if something awful might happen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Total Score (add your column scores)				
If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

HIT-6™ (VERSION 1.1)

This questionnaire was designed to help you describe and communicate the way you feel and what you cannot do because of headaches.

To complete, please circle one answer for each question.



1 When you have headaches, how often is the pain severe?

Never Rarely Sometimes Very Often Always

2 How often do headaches limit your ability to do usual daily activities including household work, work, school, or social activities?

Never Rarely Sometimes Very Often Always

3 When you have a headache, how often do you wish you could lie down?

Never Rarely Sometimes Very Often Always

4 In the past 4 weeks, how often have you felt too tired to do work or daily activities because of your headaches?

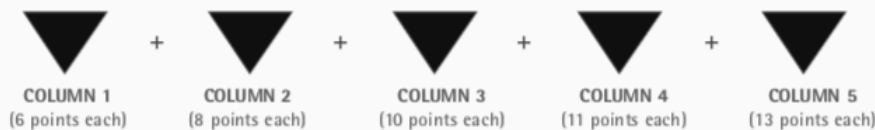
Never Rarely Sometimes Very Often Always

5 In the past 4 weeks, how often have you felt fed up or irritated because of your headaches?

Never Rarely Sometimes Very Often Always

6 In the past 4 weeks, how often did headaches limit your ability to concentrate on work or daily activities?

Never Rarely Sometimes Very Often Always



To score, add points for answers in each column.

Please share your HIT-6 results with your doctor.

Total Score

Higher scores indicate greater impact on your life.

Score range is 36-78.

Other previous treatments attempted/used previously?: (please circle)

Occipital nerve block Opioids Massage Therapy Chiropractic Therapy Acupuncture Physiotherapy

Other: _____

***PATIENT - PLEASE SIGN* - AUTHORIZATION OF INFORMATION**

I have carefully read all **6** pages of this document (*including the Medication page appended*) and confirm that the above/below stated/written information and disclosure of my personal health information is correct to the best of my knowledge.

Patient Signature: _____

Print Name: _____

PHYSICIAN / ASSESSMENT NOTES (Patients DO NOT write in this section):

MEDICATION - ***MUST BE COMPLETED***

Please **LIST ALL medications** you have tried for migraines / headaches (past & present).

You must include: **name** of drug, **dose** of drug (how many mg, how many times per day), **how long** you tried it for (days, months, years) & tell us **why you stopped using it or if you are still using it**. **For insurance purposes, this may be cross-referenced with your pharmacy/medical records.*

Medication (name of drug)	Dosing (how much; how often)	Start Date & End Date	Results/Outcome (Intolerable side effects, ineffective, etc)

**Use the medication example charts below to see if you recognize any of these medications that may have been used.*

Prophylactic Examples

Antidepressants	Antiepileptics/ Anticonvulsants	Beta-blockers	Calcium Channel Blockers	Angiotensin-Converting Enzyme (ACE) Inhibitors/ Angiotensin II Receptor Blockers (ARB)
Amitriptyline	Divalproex sodium	Atenolol	Diltiazem	Candesartan
Citalopram	Gabapentin	Metoprolol	Nifedipine	Enalapril
Doxepin	Topiramate	Nadolol	Nimodipine	Irbesartan
Fluoxetine	Valproic acid	Propranolol	Verapamil	Lisinopril
Fluvoxamine		Timolol		Losartan
Mirtazapine				Olmesartan
Nortriptyline				Ramipril
Paroxetine				Valsartan
Protriptyline				
Sertraline				
Venlafaxine				

Acute/Abortive Examples

NSAIDs/ Analgesics	Ergot Alkaloid Derivative	Triptans	Combination/Other
Acetaminophen	Ergotamine	Almotriptan	Acetaminophen/aspirin/caffeine
Aspirin	Dihydroergotamine (DHE)	Eletriptan	Butalbital/acetaminophen/caffeine
Diclofenac		Frovatriptan	Butalbital/aspirin/caffeine
Ibuprofen		Naratriptan	Butorphanol
Naproxen		Rizatriptan	Ergotamine/caffeine
		Sumatriptan	Sumatriptan/naproxen
		Zolmitriptan	

Note Regarding Private Insurance / Private Benefit Coverage of BOTOX MIGRAINE TREATMENT

- The administration of Botulinum Toxin for cosmetic purposes is strictly excluded from coverage.
- BOTOX MIGRAINE TREATMENT is not currently covered by OHIP.
- The cost of the drug itself (Botox Therapeutic) may be covered by some private insurance providers. **If you do not have private insurance, the entire cost is then paid privately by the patient. However, we do have access to a small amount of assistance (up to 20% of the cost of the drug, for a limited number of treatments per year) through a Patient Support Program if you do not have private coverage.*
- The “Injection Fee” of \$175 (+tax) is payable upon each treatment to the CLINIC (this is not covered by insurance).
- Each private insurance/benefit provider may have different criteria and requirements before consideration of covering BOTOX MIGRAINE TREATMENT.
- BOTOX MIGRAINE TREATMENT is considered a specialty therapy. Trials of “first tier” treatment (preventative oral medications) are required prior to consideration of approval for BOTOX MIGRAINE TREATMENT.
- Typically, in order to qualify for coverage of BOTOX MIGRAINE TREATMENT, you must meet certain criteria:
 - Have a diagnosis of Chronic Migraine (from your family doctor, neurologist, or Dr Tetelbaum can help determine this). The diagnosis of Chronic Migraine is defined as having 15 days or more of headaches per month (for at least the past 3 months) of which 8 days of the month were migraines days (lasting 4+ hours).
 - Have tried at least 2 (sometimes 3, depending upon insurance provider) different trials of prophylactic medications (from an approved list) for the prevention of CHRONIC MIGRAINE.
 - Medication Trials: These trials can vary from 6 - 12 weeks in length. If a trial is failed, we move on to the next trial (and so on, until the insurance criteria has been fulfilled). **A failed trial may be considered if:*
 - Unsatisfactory or no therapeutic effect (less than 30% reduction in frequency of headache days) to an adequate dose/duration of the prophylactic medication.
 - Contraindication or intolerable side effects necessitating discontinuation (depending upon insurance provider, this may only be considered for 1 of the drugs only).
 - Prophylactic (preventative) medication trials do not include ACUTE medications such as triptans, NSAIDS or OTC pain medications.
 - There is a specific list of “accepted”/approved medication types that can be used for prophylaxis. These may include (but are not limited to): topiramate, divalproex sodium/valproate sodium, beta-blockers (metoprolol, propranolol, timolol, atenolol, nadolol), tricyclic anti-depressants (amitriptyline, nortriptyline), SNRIs (venlafaxine, duloxetine), angiotensin receptor blockers (candesartan).

- Patients are required to keep a log book or tracking journal to document their headaches. Visit mychronicmigraine.ca to print copies of an excellent example of a “Headache Journal”. See example below:

SAMPLE

MY HEADACHE DIARY

Use this diary **every day** to capture information that can help you and your doctor better understand, and manage, your migraines. Each diary sheet is for one month, with a column for each day of the month. Below is a **sample diary** to show you how to use it.

HEADACHE SEVERITY: For each day you experienced a headache, please specify how severe your headache was. If you experienced more than one headache in a day, select the greatest severity.

Mild = Noticeable **Moderate** = Cannot be ignored **Severe** = As bad as it could be

DATE	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Mild				✓												✓															
Moderate					✓														✓												
Severe											✓	✓									✓								✓		

ACUTE MEDICATIONS: (Tablets/injections per day of medications taken to treat a headache).

Write the names of the acute medications you take in the blank space on the left-hand side. Put the number of tablets/injections per day that you take of each medication in the box under the correct date.

Name	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Ibuprofen/200 mg			2								2									3											
Total days <u>3</u>																															

PREVENTATIVE MEDICATIONS: (Medications taken to prevent or decrease your headache tendency).

If you are taking a preventative medication for your headache, enter the name and dosage in the blank space on the left-hand side, and fill in the number of tablets taken each day. If you receive an injection at your doctor's office, indicate this as well.

Name	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Flunarizine/10 mg	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
Total days <u>31</u>																															

Name	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
OnabotulinumtoxinA											✓																				
Total days <u>1</u>																															

DISABILITY FOR THE DAY:

Please grade the amount of disability you experienced from 0 to 3 (scale shown below). Write the number in the appropriate square for each day.

0 = None 1 = Able to carry out usual activities fairly well 2 = Difficulty with usual activities, may cancel less important ones
3 = Have to miss work (all or part of day) or go to bed for part of day

Disability	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
			1								1				0						2										

TRIGGERS:

Please write down each possible trigger and give it a number, as shown below. Record the trigger number in the table on the date when you feel that trigger contributed to your headache.

Triggers	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
1 Red wine												1									2										
2 Menstrual period																															
3																															
4																															

Adapted from Headache Network Canada